ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Provider Bulletin
Chapter A-200-11-01

Date: July 20, 2011

To: Participating Physicians, Advanced Practice Nurses, Imaging Centers, Portable X-ray Companies, School-based Linked Health Center, Local Health Department, Independent Laboratory, Hospitals, Optometrists and Dentists

Re: Chapter A-200, Handbook for Practitioners Rendering Medical Services Update Regarding Reimbursement for Hospital-Owned Off-Site Clinics

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Rulemaking regarding the department's policies for reimbursement for hospital-owned off-site clinics has been adopted and became effective June 15, 2011. This rulemaking sets forth the requirements that must be met for off-site clinic services to be eligible for reimbursement from HFS. The purpose of this bulletin is to add information on the department's reimbursement policy to the Practitioner Handbook. In addition to this change, HFS is also clarifying language regarding the reimbursement of vaccinations.

If you do not have access to the Internet, or need a paper copy, printed copies are available upon written request. You need to specify a physical street address to ensure delivery. Submit your written request or fax to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: 217-557-8800
E-mail the Provider Participation Unit

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Appendices

Procedure: Charges for the one salaried physician may be submitted on the HFS 2360 (pdf) under the physician's name and NPI. Hospitals may submit charges on the UB-04 for the APL procedure.

Salaried practitioners may not submit charges for services provided to patients who are receiving inpatient care.

=A-202.13 Allowable Fee-For-Service Charges by Hospitals

Effective Date: June 15, 2011

Hospitals may submit fee-for-service charges for the following services performed in the hospital outpatient setting at the hospital's main campus or in a hospital-owned off-site clinic within 35 miles of the main hospital campus:

- Administration of chemotherapy for the treatment of cancer
- Administration and supply of the following injectable medications
  - Chemotherapy agents for the treatment of cancer
  - Non-chemotherapy drugs administered for conditions associated with the chemotherapy and submitted with the cancer-related diagnosis
  - Baclofen
  - Lupron
  - RhoGAM
  - Synagis
  - Tysabri
- Reference (outside) laboratory services
- Outpatient laboratory and radiology services ordered by a physician
- Durable Medical Equipment and Supplies
- Speech and occupational therapy
- Services provided by salaried physicians and APNs to Illinois Department of Corrections (IDOC) and Illinois Department of Juvenile Justice (IDJJ) patients

A-202.14 Services Provided by Interns and Residents

When an intern or a resident provides medical services to a participant, the department will allow reimbursement for the services, but only to the teaching physician. The teaching physician must: 1) be personally involved in the patient's care; and 2) directly supervise the intern's or resident's activities. The employing hospital and/or teaching physician must maintain verification, which is readily available to department staff, that these requirements have been met. Such entries must be signed and dated by the physician seeking reimbursement. Signature stamps are not acceptable.

Exception: For residents beyond their first year, the department will recognize the medical school's or sponsoring hospital's protocols in the department's audit process if the protocol of each residency program meets all of the following: 1) identifies the level of supervision for each year of residency; 2) describes specific situations where residents may and may not function independently; and 3) specifies the manner in which documentation will be maintained to verify that the teaching physician has personally supervised the resident to the degree required in the protocol and has participated in the patient's care to the degree specified in the protocol. The

department will accept the medical school's or sponsoring hospital's residency program supervision protocol and other medical record documentation in the determination of whether the teaching physician has provided appropriate supervision and assumed appropriate responsibility for the services provided by the resident. If the protocol and residency records are not readily available in the event of a department audit, the medical school or sponsoring hospital will be held to the requirements specified in the first paragraph of this topic.

=A-202.15 Allowable Charges for Services Provided at a Hospital-Owned Off-Site Facility

Effective Date: June 15, 2011

Facilities Located within 35 Miles of the Hospital

Hospital Billing

Charges may be submitted for services provided at an off-site hospital-owned clinic, express care or urgent/priority care facility. The hospital may bill facility charges for procedures from the Ambulatory Procedures Listing (APL) as described in the Handbook for Hospital Services, Topic H-270. Services that fall within the limits of Topic A-202.13 of this handbook and do not contain a billable APL service may be billed fee-for-service.

Practitioner Billing

Professional services provided in conjunction with a procedure from the APL must be billed following the policy located in Topic A-202.12. Other professional services such as office visits must be billed by the practitioner who rendered the service. If billing electronically, indicate the rendering practitioner in the Rendering Provider Loop.

Facilities Located more than 35 Miles from the Hospital

A salaried practitioner may submit charges for the services provided at an off-site hospital-owned clinic, express care or urgent/priority care facility. The salaried practitioner may submit charges for office visits and for only the technical component of any laboratory or radiology services performed. The interpreting practitioner must submit charges for the professional component of the laboratory and radiology services. Charges submitted for any office visits, laboratory or radiology services performed must be submitted with place of service "office". The salaried practitioner may request that the hospital's CLIA be posted to the practitioner's enrollment file. Refer to Appendix A-15, for billing examples.

A-202.2 Electronic Claim Submittal

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3 or Chapter 300, Topic 302.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data.

A-202.3 Claim Preparation and Submittal

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions on preparing claims for Medicare covered services, refer to Appendix A-2.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendices A-1 through A-5 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scanability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Provider/Image System Liaison

A-202.4 Payment

Payment made by the department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the department.

Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

For participants eligible for Medicare Part B benefits, payment will be considered on the deductible and coinsurance amounts and/or for department's Medical Programs covered services not covered by Medicare. (See Chapter 100, Topic 120).

A-202.5 Fee Schedule

The fee schedule of allowable Procedure Codes and special billing information is available on the department's Web site. The Web site listings and the downloadable rate file are updated quarterly.

A-226 Vaccinations (Immunizations)

Vaccinations (immunizations) are covered for children based on the schedule established by the Advisory Committee on Immunization Practices (ACIP) and as described in the Chapter HK-200, Handbook for Providers of Healthy Kids Services. Vaccinations are covered for adults when the provider has determined the vaccine to be medically necessary and for preventive purposes (such as influenza and pneumonia vaccines) when administered in accordance with the Center for Disease Control's recommended guidelines.

Providers should enroll in the Vaccines for Children (VFC) program, a federally funded, state operated program. The Illinois VFC Program provides state purchased vaccine for HFS eligible children through the age of 18 years at no charge to the public or to private providers. Additional information regarding VFC may be viewed in the Chapter HK-200, Topic HK-207.2.

= Payment will be made for the specific vaccine according to the examples for children and adults in Appendix A-8 of this handbook. Reimbursement will be based on the lesser of charges or the rate posted in the State Max column on the Practitioner Fee Schedule. Specific notes are applicable to each vaccine code and are explained in the Fee Schedule Key. Reimbursement for the practice expense of administering the injection is included in the office visit when the client sees a practitioner. If the client comes in solely for the injection, the CPT Code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician may be submitted to cover the practice expense, and the specific vaccine Procedure Code is to be submitted to cover the cost of the vaccine or the cost of obtaining it through VFC. Seasonal flu vaccinations follow these guidelines.

Exception: Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) may submit charges for vaccinations only when they are administered during a billable encounter, as defined in the Chapter D-200, Handbook for Encounter Clinic Services. The detail for the specific vaccination defined by the CPT Code must be reported.

Refer to Appendix A-8 for billing examples.

Appendix A-8

Vaccinations Billing Instructions

Children 0 through 18 years of age

Example #1 A well-child examination is performed, and routine vaccinations are administered at the same time. The well-child examination is submitted using the appropriate CPT Code for the preventive medicine visit. Vaccinations are billed using the appropriate CPT Codes for the specific vaccines. The department reimburses for the visit at the fee schedule rate, for the VFC vaccine administrative services at $6.40, and for the non-VFC vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99xxx	evaluation and management code	Per fee schedule
90xxx	specific VFC-provided vaccine	$6.40
90xxx	non-VFC vaccine cost	Per fee schedule

Example #2 A child presents solely to receive a vaccine available through VFC. The salaried staff member administers the vaccine. The office visit is submitted using the CPT Code for a minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the VFC vaccine administrative services at $6.40.

HCPCS	Description	Reimbursement rate
99211	evaluation and management code	Per fee schedule
90xxx	specific VFC-provided vaccine	$6.40

Adults 19 years of age or older

Example #3 An office visit for an adult is performed for reasons other than receiving an immunization. A vaccine is then recommended and administered. The office visit is submitted using the CPT Code for the appropriate level office or other outpatient visit for evaluation and management. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the cost of the vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99xxx	evaluation and management code	Per fee schedule
90xxx	vaccine cost	Per fee schedule

Example #4 An adult presents solely to receive a vaccine. The salaried staff member administers the vaccine. The office visit is submitted using the CPT Code for the minimal level office or other outpatient visit for evaluation and management not requiring the presence of a physician. The vaccination is billed using the appropriate CPT Code for the specific vaccine. The department reimburses for the visit at the fee schedule rate and for the cost of the vaccine at the fee schedule rate.

HCPCS	Description	Reimbursement rate
99211	evaluation and management code	Per fee schedule
90xxx	vaccine cost	Per fee schedule

Appendix A-15

Billing Instructions for Hospital Owned Off-Site Clinics Facilities Located more than 35 Miles from the Hospital

Effective Date: June 15, 2011

Paper Claims	**Office Visit**	**Laboratory Services**	**Patient Not Seen By A Physician at the Clinic/Referred**	**Radiology Services**	**Patient Not Seen By A Physician at the Clinic/Referred**
Professional Components	Salaried Physician POS = Office **Billing Provider =** Physician's NPI Hospital – **Payee**	Pathologist Modifier 26 POS = Office **Billing Provider =** Pathologist's NPI (Salaried or Non-Salaried) Hospital or Pathologist – **Payee**	Pathologist Modifier 26 POS = Office **Billing Provider =** Pathologist's NPI (Salaried or Non-Salaried) Hospital or Pathologist – **Payee**	Radiologist Modifier 26 POS = Office **Billing Provider =** Radiologist's NPI (Salaried or Non-Salaried) Hospital or Radiologist – **Payee**	Radiologist Modifier 26 POS = Office **Billing Provider =** Radiologist's NPI (Salaried or Non-Salaried) Hospital or Radiologist – **Payee**
Technical Components	None	Salaried Physician Modifier TC POS = Office **Billing Provider =** Physician's NPI Hospital – **Payee** CLIA assigned to Physician	Pathologist Modifier TC POS = Office **Billing Provider =** Pathologist's NPI Hospital or Pathologist – **Payee** CLIA assigned to Pathologist	Salaried Physician Modifier TC POS = Office **Billing Provider =** Physician's NPI Hospital – **Payee**	Radiologist Modifier TC POS = Office **Billing Provider =** Radiologist's NPI Hospital or Radiologist – **Payee**

837P CLAIMS	**Office Visit**	**Laboratory Services**	**Patient Not Seen By A Physician at the Clinic/Referred**	**Radiology Services**	**Patient Not Seen By A Physician at the Clinic/Referred**
Professional Components	Salaried Physician POS = Office **Billing Provider =** Hospital's NPI **Rendering Provider =** Physician's NPI	Pathologist Modifier 26 POS = Office **Billing Provider =** Hospital's NPI, if the Pathologist is salaried by the hospital. **Rendering Provider =** Pathologist's NPI **Billing Provider =** If the Pathologist is not salaried by the hospital, the Billing Provider = Pathologist's NPI **No Rendering Provider**	Pathologist Modifier 26 POS = Office **Billing Provider =** Hospital's NPI, if the Pathologist is salaried by the hospital. **Rendering Provider =** Pathologist's NPI **Billing Provider =** If the Pathologist is not salaried by the hospital, the Billing Provider = Pathologist's NPI **No Rendering Provider**	Radiologist Modifier 26 POS = Office **Billing Provider =** Hospital's NPI, if the Radiologist is salaried by the hospital. **Rendering Provider =** Radiologist's NPI **Billing Provider =** If the Radiologist is not salaried by the hospital, the Billing Provider = Radiologist's NPI **No Rendering Provider**	Radiologist Modifier 26 POS = Office **Billing Provider =** Hospital's NPI, if the Radiologist is salaried by the hospital. **Rendering Provider =** Radiologist's NPI **Billing Provider =** If the Radiologist is not salaried by the hospital, the Billing Provider = Radiologist's NPI **No Rendering Provider**
Technical Components	None	Salaried Physician Modifier TC POS = Office **Billing Provider =** Physician's NPI Pay-To Provider = **Hospital Payee NPI** **No Rendering Provider** CLIA assigned to Physician	Pathologist Modifier TC POS = Office **Billing Provider =** Pathologist's NPI **Pay-To Provider =** Hospital or Pathologist's NPI **No Rendering Provider** CLIA assigned to Pathologist	Salaried Physician Modifier TC POS = Office **Billing Provider =** Physician's NPI **Pay-To Provider =** Hospital Payee NPI **No Rendering Provider**	Radiologist Modifier TC POS = Office **Billing Provider =** Radiologist's NPI **Pay-To Provider =** Hospital or Radiologist's NPI **No Rendering Provider**